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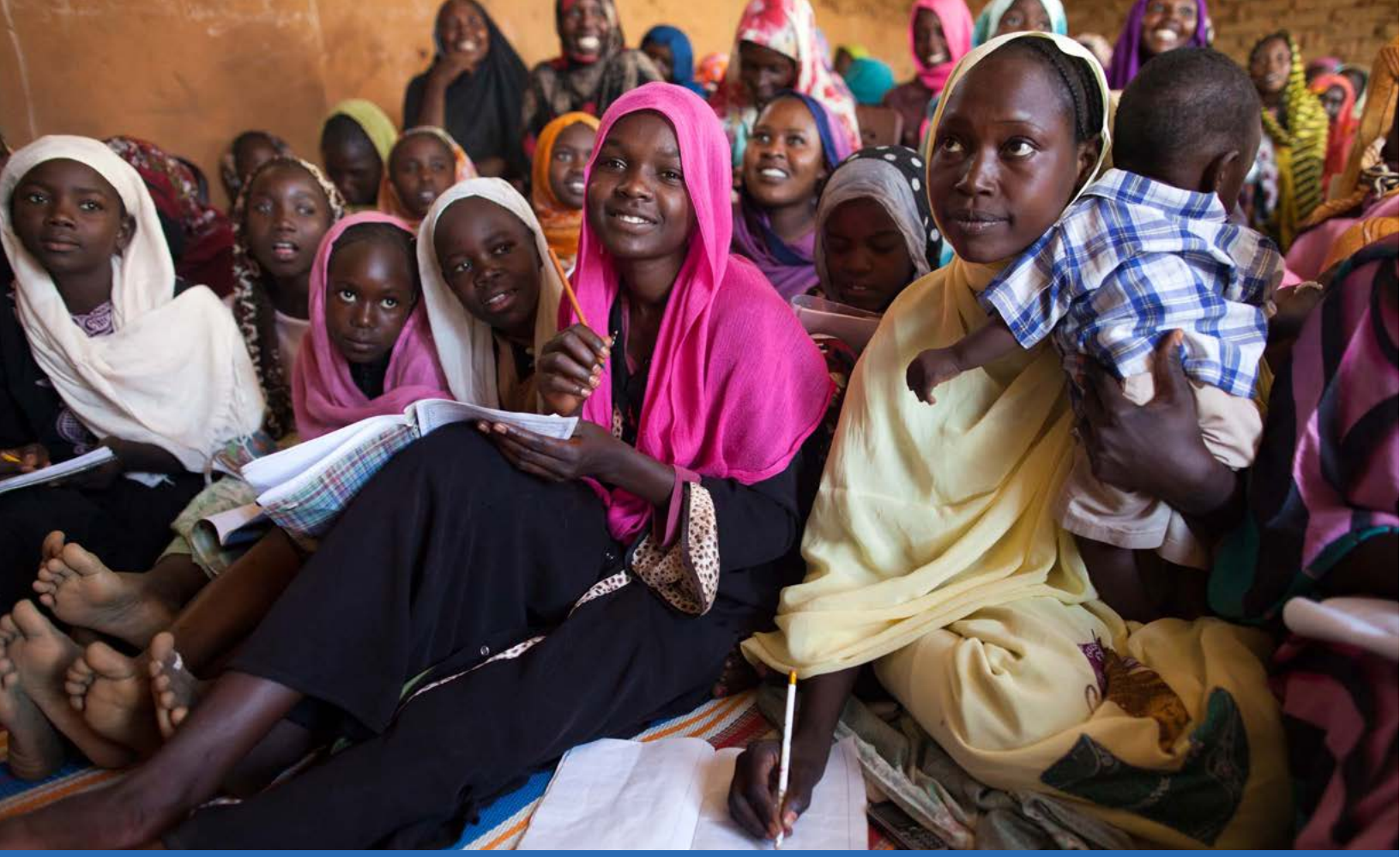
GLOBAL HEALTH AND GENDER CONSIDERATIONS IN THE HUMANITARIAN-DEVELOPMENT NEXUS

SYMPOSIUM REPORT

Co-Hosted by Canada's International Development Research Centre
and
Aga Khan Foundation Canada
Ottawa, March 12, 2020

INTERNATIONAL DEVELOPMENT RESEARCH CENTRE

Canada



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Once seen as a continuum, the boundaries of humanitarian aid and development assistance increasingly overlap, as natural disasters, conflicts, epidemics, and pandemics compound the longstanding challenges of addressing poverty and social inequality. New ways of working between humanitarian and development actors are more important than ever—especially in fragile and conflict-affected settings, and particularly in addressing the health needs of vulnerable populations. Yet the potential for greater coordination and collaboration between various actors is undermined by gaps in knowledge and different outlooks and approaches: humanitarian responses are typically short term, focused on immediate basic human needs, while development interventions focus on the long-term consequences of inequity, and building local capacity and systems. And while recent years have seen a deeper understanding emerge on the need to work more closely with peers in peacebuilding and stabilization, such coordination at the strategic level is still rare.

Fragile settings—those challenged by weak governance, ethnic tensions, extreme inequalities or other factors that may erupt into conflict and violence—also lay bare the underlying gender and social inequalities that undermine health systems, exacerbating the toll on women, girls, and other marginalized groups in society. Without disaggregated data, and deliberate efforts to reach the most vulnerable, these groups are at risk of being left behind.

On March 12, 2020, the International Development Research Centre (IDRC) and Aga Khan Foundation Canada (AKFC) jointly hosted "Global Health and Gender Considerations in the Humanitarian-Development Nexus." This one-day symposium aimed to encourage new, collective thinking about the challenges involved in bridging sectors and point to new ways forward. Recognizing the key role that research plays in bringing together key voices to identify solutions and approaches, the symposium drew together researchers, practitioners, and officials from the Government of Canada working in the areas of global health, gender equality, development, stabilization, and humanitarian response. They exchanged insights on the knowledge gaps and on how these diverse fields and communities can work together more effectively in addressing the challenges.

Through presentations, case study examples, and dialogue, speakers and participants addressed the barriers that impede greater integration at the nexus, and surfaced opportunities and approaches to strengthen gender and health interventions. The symposium also pointed to considerations for a research agenda to address knowledge gaps, using methods tailored to local contexts and circumstances.

Six takeaway messages:

- We need to deepen our understanding of the triple nexus, linking strategies across peace, humanitarian aid, and development.
- We must reconcile the short-term focus of humanitarian efforts with longer term development objectives.
- Gender-oriented health systems strengthening can be a means to transform both gender equality and health-related outcomes.
- Strategies and guidelines must be tailored to the relevant context—including fragility and conflict—and informed by evidence.
- A research agenda to bridge the nexus should be multisectoral, multidisciplinary, participatory, and focused on reducing health and gender inequities.
- Communities and local civil society need to be engaged in decision-making across the nexus.

DEFINING THE CHALLENGE

Montasser Kamal, IDRC Program Leader for Maternal and Child Health, Dominique Charron, IDRC Vice-President, Gwyneth Kutz, Director General, Global Affairs Canada's Peace Stabilization Operations Program, Khalil Shariff, CEO, Aga Khan Foundation Canada.

In opening the symposium, IDRC Vice-President Dominique Charron outlined many of the multiple complicating factors that characterize the development challenge today. Beyond poverty and inequality, protracted regional conflicts are compounding the situation. By 2030, half of the world's extreme poor will live in countries characterized by fragility, conflict, and violence. Displacement tied to regional conflicts is most heavily felt in neighbouring countries, where health and social support systems are overwhelmed by the magnitude of the needs. Of the current 25.4 million refugees, 84% are hosted in low- and middle-income countries.

For IDRC, whose mission since 1970 has focused on building knowledge and research capacity in low- and middle-income countries, these protracted crises challenge traditional ways of working. "Like other development aid agencies," said Ms Charron, "we are increasingly finding ourselves supporting work in fragile contexts, considered traditionally to be the domain of humanitarian aid agencies." At the same time, there is a clear need for research to inform evidence-based decision-making in development and humanitarian settings: "There is a persistent lack of accurate, disaggregated, and timely data on women, children, and other marginalized groups—making them 'invisible' and exacerbating their vulnerability."

> "[W]e are increasingly finding ourselves supporting research for development in fragile contexts, considered traditionally to be the domain of humanitarian aid agencies."
>
> *Dominique Charron*
> *IDRC Vice-President*

Khalil Shariff, AKFC's CEO, also underscored the breakdown of traditional understandings on the links between humanitarian action and development as being sequential. "We have transcended that," said Mr. Shariff. "Humanitarian and development issues

"[It's] not simply about understanding vulnerability through a new lens, but about unleashing the agency of women and girls who have been systematically excluded."

Khalil Shariff, CEO of AKFC

occur simultaneously." This challenges various actors to think about how their programming can build for the future while addressing more immediate humanitarian needs. With regards to gender equality and women's empowerment, AKFC's experience has revealed not just that women face particular vulnerabilities, but that they also represent an enormous opportunity. He pointed to the example of women's increasingly visible role in peacemaking, which has made an indelible difference in the ability for peace to be sustained. "With the right kinds of support, we have massive opportunities to unleash the agency of these women. [It's] not simply about understanding vulnerability through a new lens, but about unleashing the agency of women and girls who have been systematically excluded."

As Gwyneth Kutz, Director General of Global Affairs Canada's Peace Stabilization Operations Program (PSOPs), underscored, there has been longstanding recognition of the need for greater coherence across peace, development, and humanitarian efforts. She cited a range of policy initiatives urging coherence as far back as the 1980s and most recently, the 2016 New York Declaration on the Humanitarian Development Nexus. As the Canadian platform for conflict prevention, stabilization and peacebuilding, PSOPs must continuously think about and plan for nexus contexts. "Tackling this challenge isn't just a matter of figuring out how to work side-by-side with development and humanitarian colleagues," she said, "it's a recognition that our success depends on deeper integration."

BARRIERS THAT HAVE UNDERMINED EFFECTIVE RESPONSE AND COORDINATION

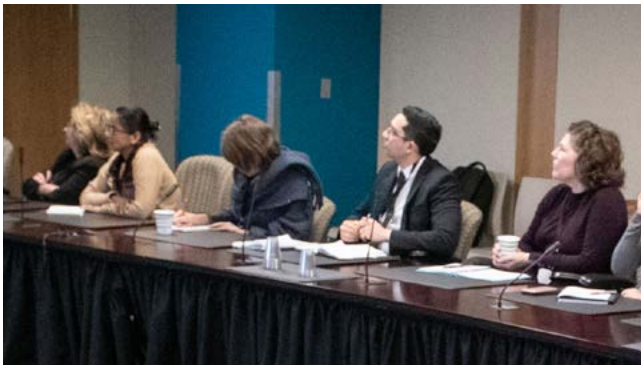
Various barriers were identified and explored over the course of the day, including operational silos and a shared lack of vision; data gaps—in particular due to a lack of socially disaggregated data—that resulted in blind spots in our thinking about development and the consequences of conflict and fragility; and gender biases in the health system.

Organizational silos

While pointing to a number of areas of progress in increasing policy and programming coherence in recent years, Gwyneth Kutz highlighted the need for organizations to scrutinize internal practices for factors that impede greater integration. She pointed to deeply entrenched silos in institutional mandates, funding channels, and corporate cultures across development, humanitarian, and peace and security mechanisms. She challenged researchers to explore the organizational factors that impede progress in addressing these silos, given the known advantages of coherence. And she asked practitioners to share their organizational insights on what factors undermine their "fitness" for the nexus.

"What are the incentives inside our organisations that cause people to keep working the way they do? What are the cultural barriers which impede greater humanitarian, development, and peacebuilding integration?"

Gwyneth Kutz, Director General, PSOPs



Isabelle Mercier and Laurent Tran of Global Affairs Canada's International Assistance Evaluation Division (far right).

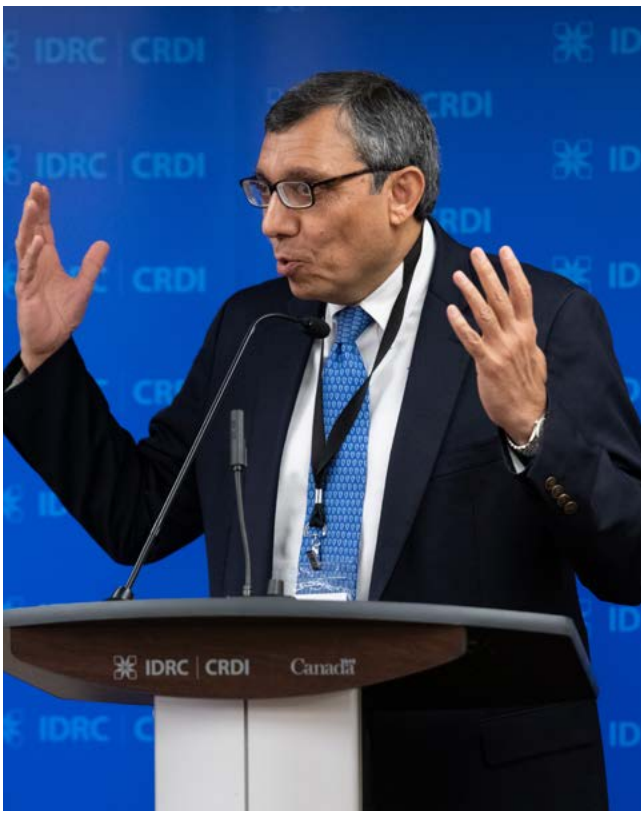
Isabelle Mercier and Laurent Tran of Global Affairs Canada's International Assistance Evaluation Division elaborated on both successes and ongoing constraints to field-level coherence among humanitarian, peace, and development actors. They cited findings from recent evaluations—including of country programs in Colombia, Ukraine, and the Democratic Republic of the Congo and of international humanitarian assistance—which have integrated key questions on coherence. The evaluations found evidence in some projects of nexus coordination happening at the field level. In Colombia, for example, demining activities were coordinated in such a way as to enable the safe entry of development projects that support agricultural cooperatives and other productive activities. System mapping in the Democratic Republic of the Congo, however, showed that a number of organizations were working in several sectors at the same time, not necessarily related to their sectors of intervention (humanitarian, development, or peace), with coordination limited by their varied funding sources.

Ms Mercier pointed to structural factors that can make coordination difficult. This is not unique to the Canadian context: evidence has shown that a number of other donors face similar challenges when it comes to implementing in the humanitarian-development nexus. Humanitarian actors remain apolitical, with responses largely short-term and focused on saving lives. On the funding side, disbursement is often rapid, and without the same requirements for monitoring and evaluation that underpin programming on the development side, which is longer-term in its outlook for poverty alleviation and sustainability, and tends to align more with global priorities. These structural differences make it difficult to systematically connect decisions and programming at the country or field-of-implementation level. There are few opportunities for joint planning and response, especially in areas with protracted crises and these need to be pursued more vigorously.

Data gaps—What's been missed

Dr Zulfiqar Bhutta, a global health expert currently affiliated with Aga Khan University and Toronto's Hospital for Sick Children, focused on the obstacles to more effective health care for women, children, and adolescents in conflict settings. He began by reviewing progress on addressing maternal, child, and infant mortality under the 2000-2015 Millennium Development Goals (MDGs). While the global target of reducing child mortality by two-thirds was not reached, substantial progress was made on both maternal and child health. But much was missed. Dr Bhutta credited former UNICEF CEO Anthony Lake with the recognition that aggregated national statistics were masking deep inequities in whose health outcomes were improving—overall gains were made at the expense of the rural and urban poor, indigenous groups, those in conflict zones, those with disabilities, and girls.

Another major blind spot highlighted by the Independent Expert Review Group (iERG), which monitored MDG progress, was adolescent health. This

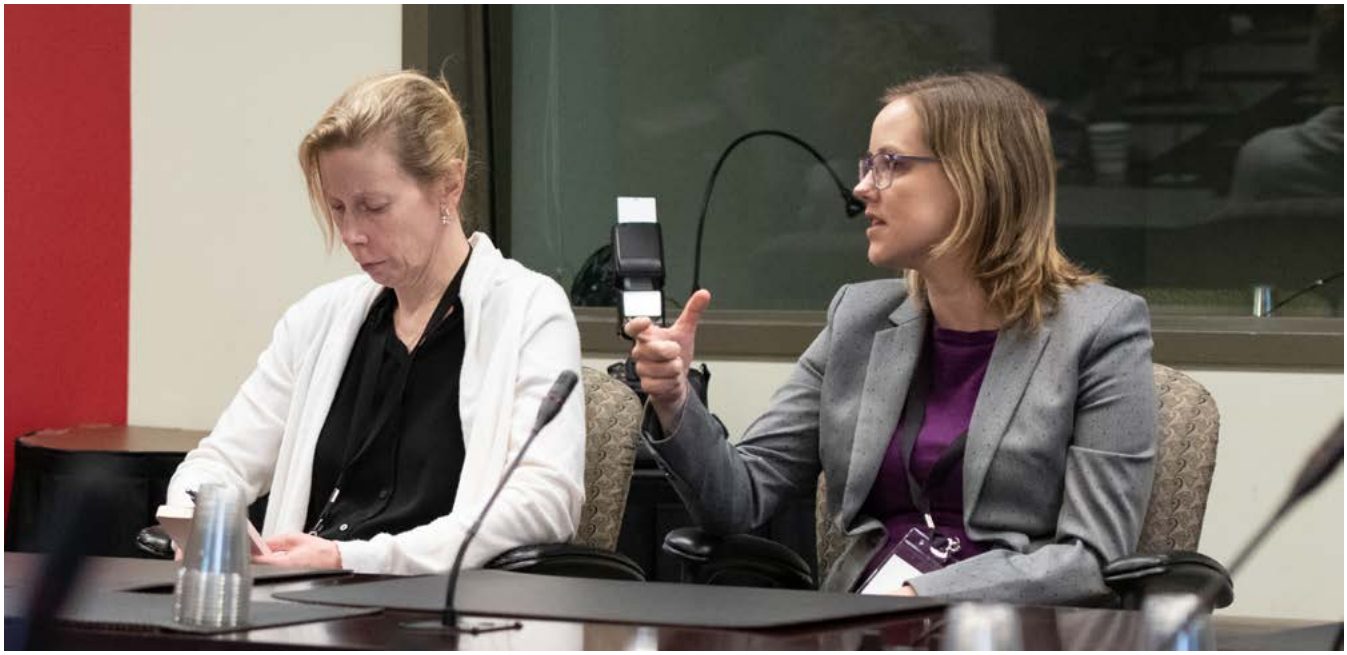


Dr Zulfiqar Bhutta

15- to 19-year-old group was completely missing in the MDGs, and there were no adolescent-specific outcomes in the iERG's 2013 report, Every woman, every child. Dr Bhutta pointed out that this was not just important for girls, but for boys. The highest levels of adolescent mortality are for young boys (mainly due to trauma, accidents, and violence), largely clustered around the poorest of the poor. He also pointed to a "missing middle"—the lack of mortality and morbidity data on those between five and 14 years of age. While this is considered a group at lower risk, data from India, China, Mexico, and Brazil suggest non-communicable disease within this age group remains significant, while India still has much ground to cover in addressing infectious disease among children over five.

> "When you disaggregate, you see the tremendous failures—those left behind on the basis of gender, ethnicity, geography, and context, especially that of conflict."
>
> *Dr Zulfiqar Bhutta, Aga Khan University and Hospital for Sick Children*

Context is also vitally important in determining health outcomes in the nexus—especially the presence or absence of conflict. Dr Bhutta cited recent research on maternal, newborn, child and adolescent health in Muslim-majority countries (Lancet 2018) that found significant gaps in outcomes between conflict and non-conflict states. These gaps are also evident in global research that shows conflict countries had consistently higher maternal and child mortality rates than non-conflict countries, and that within conflict-affected states, the most disadvantaged mothers and children were the rural, the poorest, and the least educated (BMJ Global Health 2020). Structural and contextual factors, especially state governance, conflict, and women and girl's empowerment indicators, were shown to be strongly associated with child and newborn mortality within low- and middle-income Muslim-majority countries.



Dr Valerie Percival of Carleton University , AKFC Senior Gender Equality Advisor Lindsay Mossman.

Confronting gender biases in health systems

In introducing their interactive session on gender and health at the nexus, Valerie Percival of Carleton University and AKFC Senior Gender Equality Advisor Lindsay Mossman highlighted the potential for health systems to transform social norms related to gender, but outlined a range of ways in which the system currently reinforces these norms.

"There's been a decline in maternal mortality, but this tends to plateau—often due to problematic gender norms that impede access."

Dr Valerie Percival, Carleton University

Dr Percival cited considerable skepticism among health practitioners and academics about the need to incorporate gender and an understanding of gender norms. Among health workers, there is an assumption that health services are professional, technical, and evidence driven. They feel that with women representing the majority of service users, they are already overwhelmed by the health response in the nexus. Some academics argue that advancing a western conception of gender equality is a continuation of neocolonialism and neoliberalism, and puts too much burden on the shoulders of women.

"Health services are never gender neutral."

Lindsay Mossman, AKFC

As Ms Mossman outlined, gender inequities manifest in many ways through today's health systems, from their role in reinforcing women's caregiving role and their failure to promote women's leadership in the health sector, to their chronic underfunding of comprehensive sexual and reproductive health services and the dominance of men in decision-making structures. The nexus forces us to confront these inequities, as they may be among the factors contributing to a plateau seen in the efficacy of reproductive and maternal health interventions.

REMEDIES AND OPPORTUNITIES: WHAT'S WORKING

Presentations and interactive sessions addressed potential remedies to the gaps in coordination and data, while highlighting opportunities to strengthen both gender and health outcomes at the nexus. These included efforts to gather and analyze better and more contextualized data, which among other things can help to strengthen guidelines for those working in fragile and conflict-affected areas; more inclusive and locally-contextualized research and delivery approaches; using health systems to transform gender roles and norms, and overcome exclusions; using evaluation to guide frameworks that will strengthen the coherence of peace, aid, and development programming; and innovations in health information and technologies.

Improving health delivery guidance through better evidence

Dr Bhutta shared insights from the IDRC-supported Building Research and Action in Conflict Settings for the Health of Women and Children (BRANCH) consortium, which links seven core academic institutions and their many international partners. BRANCH focuses on bringing clarity to both the language and data surrounding maternal and child health in conflict settings, using a variety of research and analysis methods. One of the pressing challenges is to remedy the current lack of guidance suitable for operating in areas affected by conflict and fragility. As Dr Bhutta noted, many current guidelines on addressing humanitarian emergencies are based on data derived from stable camp settings, which do not necessarily reflect the reality of a large portion of the affected population. Some 80% of refugees do not live in camps.

Dr Bhutta gave highlights from recent research to illustrate how "better numbers" are bringing new clarity on the relationships between conflict and maternal and child mortality rates and related health outcomes. In Africa, for example, between 1995 and 2015, over 11 million deaths of women and children were a direct or indirect consequence of conflict. Infant deaths in this time were 3.2 to 3.6 times higher than deaths caused directly by conflict. Geospatial analysis shows a statistically significant relationship between the intensity and duration of conflict and the numbers of deaths. The likelihood of being orphaned in Africa is 42% higher in conflict zones.

One of the consequences of the lack of clear, evidenced-based guidelines for operating in conflict zones is that health delivery strategies can be poorly designed, such as by clustering resources in hospitals that have been shown to be highly vulnerable to attack. Conflict zones may demand a more mobile and flexible distribution of health services.

Innovative research and delivery approaches that address gender and health in the nexus

Presentations and discussion on implementation research experiences suggest that closing the nexus gap is not just a question of having better data, but also of using better, more inclusive research approaches in fragile contexts. Explorations of three different cases—two in South Sudan and Uganda, and one in Afghanistan—point to the value of participatory research and delivery methods that engage and empower local groups; close collaboration with local partners; flexibility in responding to changing needs and circumstances; and the imperative of planning in a deliberate and informed way to bridge between humanitarian and development programming in conflict-affected or fragile settings.

Loubna Belaid of McGill University

Loubna Belaid of McGill University described recent efforts in northern Uganda and southern Sudan to assess the impact of a **participatory community-based intervention on women's empowerment in conflict and post-conflict settings**. Working with local partners (in Uganda, St. Mary's LACOR hospital; in South Sudan, the state Ministry of Health) researchers took a critical conscientization approach to exploring how marginalized communities could self-mobilize to better address local health priorities. Working with existing women's savings groups—rather than creating new parallel structures—was key. The intervention involved training facilitators chosen by each group, who then led the women's groups in identifying their own priorities and strategies that could be implemented with the support of local community members, including men. Strategies that women chose included fighting malnutrition by growing nutritious foods; fighting malaria and diarrhea by cleaning water sources; tackling teenage pregnancy by engaging boys and girls in producing soap; and improving roads for better health and education access. Groups were then encouraged to assess and reflect on the success of their strategies.

The research team conducted a nested qualitative study to assess the impact of this participatory approach on women's empowerment, based on Amartya Sen's capability approach.

Preliminary results—so far qualitative only—suggest the intervention has had some impacts on health functioning, such as increased adoption of healthy behaviours; greater use of health services; and in some instances, more inclusive reflection by couples on family size and child spacing. There also appears to be some improvement in "complex functioning" such as a reduction in domestic violence and mistreatment of children; improvements in women's ability to contribute to families' financial needs; and an increase in women's networking and communication skills.

Having local partners and people on the ground who interacted daily with the women's groups, while letting them make their own decisions, favoured the realization of groups' goals. Factors that spurred community engagement included the use of visual tools, the presence of social cohesion, and high levels of community responsiveness. In drawing lessons from the experience, Ms Belaid highlighted that fragile settings offer a chance to do things differently and underscored the value of participatory research in tackling the social determinants of health.

Dr Najmuddin Najm, CEO of Aga Khan Foundation Afghanistan, led a session on **the Health Action Plan for Afghanistan, a multi-stakeholder partnership to improve the health of women and children under five**, which was co-funded by Global Affairs Canada, Agence Française de Développement, and AKFC. Implementation took place in 37 selected districts in Badakhshan, Bamiyan, and Baghlan. By focusing on the quality and availability of health care staff, improving health services targeted to rural areas, and engaging civil society to support healthy practices around gender and nutrition, the Action Plan aimed to address access barriers and advance gender equality in health services and interventions.

Dr Najm pointed to considerable achievements on both the supply and demand side, including a new 140-bed Bamyan Provincial hospital, a new obstetric unit at the French Medical Institute for Mothers and Children serving 43,000 mothers and children, and mobile vaccination of 31,000 hard-to-reach children under the age of two (50% girls). Some 2,900 new health workers have been qualified at national and provincial

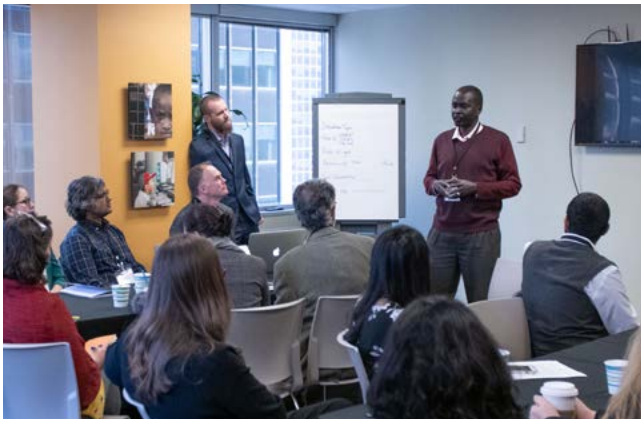
levels—over a third of them women—while 45 medical specialists were qualified at the post-graduate level. In communities, more nutritious crops are being grown, and over 1,000 sanitation and water supply points have been constructed.

Among the lessons learned, Dr Njam highlighted:

- the importance of taking a multi-sector, multi-agency approach that engages government and non-governmental actors;
- the need for close coordination and partnership with local communities: working with the Ministry of Public Health and other stakeholders was imperative in areas subject to security challenges; and
- the use of participatory gender-integration approaches that create awareness among community members, and engage them to revise approaches and focus on sensitive issues.

In a third case study presentation, a trio of researchers presented lessons from IDRC-supported research led by BRAC in South Sudan and Uganda, where gender and health come together in a context of conflict and displacement.

Kevin McKague of Cape Breton University's Shannon School of Business shared lessons from one study that involved **a randomized control trial looking at how community health workers can be better incentivized** through financial and non-financial means. Results and key insights included the importance of non-financial incentives, such as social recognition, in motivating volunteer community health workers. Another component of **research explored gender-related constraints on community health work and strategies to address them.** Key insights included the specific gender-based constraints that female health workers can face—such as safety concerns, the heavy existing burden of work, and limitations on access to capital and transport—and strategies governments and NGOs can use to overcome them.



Kevin McKague of Cape Breton University's Shannon School of Business , Odwa Atari of Nipissing University, Logan Cochrane of Carleton University

Odwa Atari of Nipissing University related how the outbreak of renewed conflict of 2016 in South Sudan forced a change of focus to instead work with Sudanese living in refugee settlements in Uganda. With seed funding from Grand Challenges Canada, research explored the links between livelihoods and health among refugees and their host communities in Uganda, working with local village health teams, village savings and loan associations (VSLAs), and livelihood empowerment and training groups to support income-generating activities and improve health and well-being. The experience has demanded considerable flexibility and adjustment, responding both to the crisis and the changing needs and realities on the ground. For example, while the team had intended to create cooperatives, it found that VSLA members (who are predominantly women) struggled with basic literacy, which made planned training on financial literacy difficult. So researchers themselves worked with local groups and individuals to help them build their required basic livelihood skills.

Logan Cochrane of Carleton University and Hawassa University shared reflections from a **2018 learning initiative focused on how to do better programming in nexus situations**, undertaken by Global Affairs Canada and implementation partners. It suggested that, rather than think of doing development programming with some form of "crisis modifier", the emphasis from the outset needs to be on intentional, informed, and proactive bridging across the humanitarian-development divide.

Advancing gender and health outcomes through transformative approaches

Beyond highlighting how health systems can replicate and reinforce gender inequalities, Dr Valerie Percival and Lindsay Mossman pointed to ways in which these systems can instead play a transformative role in advancing better health and social equality. This demands reflecting on how gender equality is addressed across all the building blocks of health systems—from their organization and governance, delivery mechanisms, and human resourcing, to their information and finance systems and their access and use of medications and technologies. It also demands looking at the "mortar" that holds together these building blocks, such as the values assigned to gender norms.

To explore opportunities to advance gender equality and health outcomes at the nexus, symposium participants were invited to examine and discuss three case studies: (1) Mozambique, where sexual and reproductive health and rights services were upended in the wake of two cyclones in 2019, even as armed violence in the country's North exacerbated existing challenges; (2) Uganda, where the delivery of primary health care depends heavily on volunteer community health workers (CHWs), the vast majority of whom are female; and (3) Afghanistan, which has some of the world's highest rates of maternal and child mortality in a context of longstanding conflict and insecurity, and where women have very limited engagement in formal health governance or other leadership roles.

In each of these cases, groups highlighted opportunities to address how inequitable gender norms could be tackled to achieve more effective outcomes, while acknowledging there remain significant barriers. In both Uganda and Mozambique, for example, there is an opportunity to increase the participation of men as CHWs, which in turn could help engage men in addressing the challenges of unpaid work, harmful gender norms, and toxic masculinities in tandem with their training. The voluntary nature of this role remains a challenge, and alternate means of income generation have to be looked at for CHWs. In Afghanistan, health shuras play a very important role in grassroots decision-making; increasing women's participation in them could be one path to giving women more voice in health services. At the same time, their mere presence in health action groups does not guarantee their needs are met.

In summary, Dr Percival described the health sector as uniquely placed to address gender issues. She pointed to the clear need for the health system to assume responsibility for gender equality, and to integrate gender-responsive approaches to health service design and delivery. This takes a change in mindset and evidence-based tools.

Using evaluation to tackle organizational and sectoral silos

Even as evaluations highlight successes and failures in coordinating peace, development, and humanitarian responses in contexts of crisis, discussion suggested that they also have a role to play in providing the clear evidence needed to inform decision-making and strengthen coordination. As Isabelle Mercier and Laurent Tran noted, the question of coherence is prominent within the recently reviewed OECD DAC evaluation criteria. As GAC moves forward on evaluations of the thematic action areas under the Feminist International Assistance Policy, it may be possible to overcome some of the limitations to examining coherence inherent in past country-focused evaluations.

Ms Mercier underscored the need for clear expectations and responsibilities among the different departmental actors with respect to nexus programming, especially in contexts where several departmental actors are operational. She also highlighted opportunities to explore joint planning, increased knowledge sharing, and improved collaboration at the country level.

Valerie Percival presented another promising evaluation-focused research initiative that may advance coherence

Reports on all recently conducted evaluations of Canada's international assistance programs can be found here: www.international.gc.ca/gac-amc/publications/evaluation

at the nexus: the Lancet-SIGHT Commission aims to examine the relations between key indicators of health, gender equality, conflict, and peace; the impact of improved health and gender equality on peace; and the institutions that shape health and gender equality. Within the Commission, a metrics working group is focusing on the empirical evidence base, to clarify the strengths and limitations of health and gender indicators to better analyze how health and gender are shaped by the broader socio-political context. The commission will focus on how improvements in gender and health equity could potentially reduce violent conflict and promote stability. "If you look at the indicators," said Dr Percival, "there are clearly vicious cycles fueled by the links between health inequities, gender inequity, and social or organized violence. By reducing gender and health inequities, is it possible to transition towards virtuous cycles?"

"By reducing gender and health inequities, is it possible to transition towards virtuous cycles?"

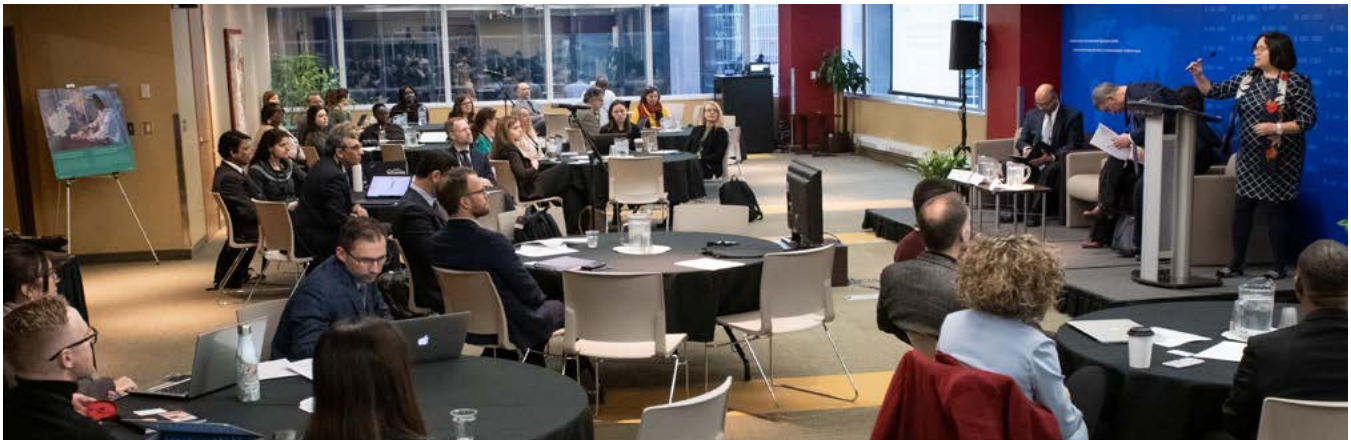
Dr Valerie Percival

Using technology and innovation to close gaps at the nexus

The challenges of working at the nexus create opportunities—and often the need—to do things differently. Representatives from CARE Canada, the Canadian Red Cross, and the Aga Khan Development Network (AKDN) presented recent experiences in using information technologies and new models of community engagement to address health and women's empowerment in fragile settings. Discussion on technology innovations pointed to the need for care in protecting privacy and considering the security vulnerabilities in conflict zones.

Saleem Sayani, Director of the AKDN Digital Health Resource Centre, shared insights from using digital technologies to support health services in remote and fragile areas of six countries in South and Central Asia and East Africa. From 2007-2019, their efforts have included 47,214 teleconsultations, 1,565 e-learning sessions, and the training of 16,191 health professionals, in 37 sites across South and Central Asia. The initiative was extended to Kenya and Uganda in 2018. Using mobile applications to connect health workers to expert resources has helped address several gaps, including the poor maternal, newborn, and child health outcomes in Afghanistan and Pakistan; the health systems' lack of transparency, accountability, and effective monitoring; and the limited reach of health workers in remote areas. A recently published paper, coauthored with a World Bank economist, found that in five years with a US$2 million investment, the initiative saved over US$9 million and 213 years of time avoided. A key lesson learned is that mobile technology is a game changer in providing access. Cellphone penetration is over 70% in Pakistan and high in other countries as well, so this is an effective platform to connect users. AKDN has seen interest from local government stakeholders in taking over the Hayat maternal health application, with training provided for long-term sustainability.

Faiza Rab presented on how Red Cross Canada was adapting its health information systems and using mobile data collection to support its field coordination. It recently piloted the integration of features to ensure



"Making sure money and power is in the hands of women themselves—that's what makes this transformative."

Maxime Michel, CARE Canada

minimum standards of protection, gender, and inclusion in emergency response. Kobo and Magpie are two data entry systems that are being used to replace Excel sheets, which were difficult to use and resulted in a lot of missing data. Ms Rab also described how Red Cross Canada works to develop the capacity of local Red Cross agencies and other local partners so that they can take over the longer term recovery and development stages after initial emergency response. They also aim for gender balance in their work with local communities.

Maxime Michel presented CARE Canada's Women Lead in Emergencies (WLiE) model for building women's collective agency during crisis response. Unlike projects that typically engage women as part of longer term recovery and development, WLiE aims to get women to the table as part of the immediate response effort. This is done by engaging women through five essential steps—reflect, analyze, co-create, act, and learn. Women's groups themselves identify barriers to their participation in community decision-making and leadership; they are then supported in identifying activities to overcome these barriers, to act upon these ideas, and to learn from them. Ms Michel shared some results from a pilot undertaken in Uganda with refugees from South Sudan, which suggest women are taking on formal leadership roles or intend to stand in camp elections. When combined with a Role Model Men and Boys program, WLiE is effective in challenging negative gender norms, such as encouraging men to help with domestic tasks, and promoting more open marital communication to reduce domestic violence. There are challenges however: the model takes time and demands local expertise. Women also identify more immediate and pressing needs, such as for firewood and livelihood options, before they can focus on leadership and collective action.

CONCLUSIONS AND WAY FORWARD

In their closing remarks, Steve Mason and Montasser Kamal offered reflections on the barriers and opportunities raised in the day's sessions, and those that lie ahead. Mr. Mason, Director of Programs for AKFC, reiterated the vital need for humanitarian actors to respect, rather than displace, local capacity that has been built over time. He offered the example of how Aga Khan Foundation investments over many years in local systems and institutions in northern Mozambique were vital to equipping local women's groups and community organizations to be first responders in addressing the impact of new forms of conflict and natural disasters. Yet there is now a real struggle as external actors step in on humanitarian response, creating parallel systems—each with their own approach—often bypassing local actors.

Montasser Kamal, IDRC Program Leader for Maternal and Child Health, recapped some of the day's key insights—on the widening inequities despite global progress on the MDGs and Sustainable Development Goals, the pressing issue of the vast population of those forcibly displaced, and the vital role that properly supported health systems can play in addressing gender inequalities. He then offered some initial observations on potential directions for research and evidence generation, including the need for implementation research to look beyond refugee camp settings; a focus on the "how" rather than the "what"; the ongoing need for disaggregated data and evidence to reveal the extent of exclusions; and the importance of ethics in interacting with these most vulnerable populations.

Looking forward, the symposium helped to surface new questions and insights relevant to researchers, practitioners, and officials guiding investments and programming at the nexus.

1) **We need to deepen our understanding of the triple nexus, linking peace, stabilization, and conflict prevention strategies with those in humanitarian aid and development.** The three sectors in this triple nexus need an overarching vision to align their respective strategic visions for greater coherence in programming, enhanced funding flows, and improved communication and knowledge sharing.

2) **It is crucial to reconcile the short-term focus of humanitarian efforts with longer term development objectives** given the potential for crisis response to undermine local capacity and existing health systems. Conversely, preparedness is generally missing in development approaches and should be integral, for example, to development goals for health systems strengthening.

3) **Health systems-strengthening approaches during humanitarian responses have the potential to transform both health- and gender-related development outcomes.** This demands an intentional focus on how gender equality is reinforced—or undermined—at all levels of the health system. We need to better understand how we can transform the vicious cycle of health inequality, gender inequality, and increasing conflict/violence in the triple nexus into a virtuous cycle of health equality and gender equality, leading to greater peace and security.

4) **Strategies and operational guidelines have to be more tailored to the relevant context—particularly with regards to fragility and conflict—and informed by evidence.** Most global guidance in the health sector is based on evidence that either does not reflect a crisis context, or is not specific to a given kind of crises. Conversely, guidance in the humanitarian sector does not allow for system-building responses to improve the health of stable (host and refugee) populations, even as the duration spent by refugees in many locations has grown exponentially in recent years.

5) Innovations in research approaches and the use of technology can improve synergies across the triple nexus. Research can thus serve as a means of linking various nexus players. **A research agenda to bridge the nexus will need to be multisectoral and multidisciplinary, incorporating participatory approaches and focusing on health and gender equity**—including through better data and evidence disaggregation.

6) **Communities and local civil society need to be involved in decision-making across the nexus.** Programs and solutions that donor agencies transfer from one context to another often lead to sub-optimum results. The active participation of communities, representative of all members, and civil society organizations can overcome this challenge.

SYMPOSIUM AGENDA

Time	Session	Speakers	Moderator
8:30 am	Registration		
9:00 am	Welcome and setting the stage	• Khalil Shariff, Chief Executive Officer AKFC • Gwyneth Kutz, Director General, Peace Stabilization Operations Program Global Affairs Canada (GAC) • Dominique Charron, Vice-President – IDRC	Montasser Kamal (Team Lead IDRC)
9:30 am	Session 1 – The Global Landscape	• Zulfiqar Bhutta – Hospital for Sick Children and Aga Khan University	Arjan De Haan Director IDRC
10:15 am	Health Break		
10:35 am	Session 2 – Implementation research in H-D Nexus context	• Loubna Belaid – McGill/University of Montreal – Uganda/South Sudan project • Kevin McKague/Odwa Atari/Logan Cochrane – BRAC South Sudan/Uganda project • Dr. Najmuddin Najm, CEO AKF Afghanistan	Fawad Akbari – AKFC World Café styled session
12:00 pm	Lunch		
01:00 pm	Session 3 – Gender equality considerations in the H-D Nexus	• Valerie Percival – Carleton University • Lindsay Mossman – Senior Gender Advisor AKFC • Sarah Harrisson/Elizabeth Opio Onyango – Cape Breton/Waterloo	Qamar Mahmood - IDRC Workshop session
02:30 pm	Session 4 – Technology and innovation to address H-D Nexus challenges	• Saleem Sayani – Director dHRC Aga Khan Development Network • Maxime Michele – CARE Canada • Faiza Rab – Canadian Red Cross	Adrijana Corluka - IDRC
03:15 pm	Health Break		
03:30 pm	Session 5 – Working across actors in the H-D Nexus	• Isabelle Mercier – Deputy Director, Internal Assistance Evaluation, GAC • Laurent Tran – Senior Evaluation Officer GAC • Valerie Percival – Carleton University	Colleen Duggan (Team Lead IDRC)
04:30 pm	Final words	• Steve Mason – Director of Programs, AKFC • Montasser Kamal – Team Lead IDRC	

Photo: Asian Development Bank

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